PUBLIC HEALTH SERVICES DISTRICT
COCONINO COUNTY

Vaccine Screening Form

Patient Information			
Patient Name: Last	First		DOB (MM/DD/YY): / /
□ AHCCCS □ Insured □ Uninsured □ Native America/Alaskan Native □ Underinsured (Vaccines not covered by Insurance)			Vaccines requested:
Age:	Female □	Male □	Transgender □

Medical History of the person receiving the vaccinations:	Yes	No	Not Sure
Is the person sick today?	□	□	□
Does the person have allergies to anyfood (such as eggs or gelatin), to medications or to latex? If yes, what allergies?	□	□	□
Does the person have any allergies to a vaccine component or has the person ever had a serious reaction to a vaccine in the past? Please let the nurse know if you have gotten dizzy or fainted after a vaccine.	□	□	□
Does the person have cancer, leukemia, HIV/AIDS, or any other immune system problem?	□	□	□
In the past 3 months, has the person taken medications which weaken the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Chron's disease, or psoriasis; or had radiation treatment?	□	□	□
Has the person themselves, siblings, or parents ever had a seizure, brain or other nervous system disorder (such as Guillan-Barre Syndrome?)	□	□	□
In the past year has the person received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	□	□	□
If the person is a baby, have you ever been told that he/she has had intussusception?	□	□	□
Is the person being vaccinated pregnant or is there a chance she could become pregnant during the next month?	□	□	□
Has the person ever had the chicken pox illness?	□	□	□
Has the person had any vaccinations in the last 4 weeks?	□	□	□
Has the person brought with them his/her immunization record today?	□	□	□

Screening for the Injectible Influenza Vaccine Only	Yes	No	Not Sure
If the patient is 8 years old or younger, has he/she received 2 or more doses of flu vaccine before this flu season (July 1, current year)?	□	□	□
Has the person received a flu vaccine this season (since July 1, current year? If yes when?	□	□	□

By signing below I certify that the information I have provided is true and correct to the best of my knowledge. I understand that the patient will be screened for needed, recommended, and requested vaccines and that I will have the opportunity to obtain information and ask questions. I have received a copy of the Patient Rights and Responsibilities and the HIPAA Confidentiality Notice.

Patient/ Guardian Signature Date

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FOR STAFF

□ Contract: _____ Vaccine Cost _____ Admin Cost _____

□ Client Card / Cash / Check **Total** _____

□ Insurance: _____ Receipt #: _____

Patient Name: **DOB:**

Vaccination Details: **VFC/VFA Eligible: Yes / No**

Vaccine	Signature of person to receive vaccine or person authorized to give consent	Notes	Fee
Cholera			
DTaP / TdaP / Td			
Hep A			
Hep B			
HIB			
HPV 4 / 9			
Inactivated Flu			
Polio			
Japanese Encephalitis			
Meningococcal 4-Valent			
Meningococcal B			
Measles, Mumps, Rubella			
PCV13 / PPSV23			
Rabies			
Rotavirus			
Typhoid VI / ORAL			
Varicella			
Yellow Fever			
Shingles			

Initials	
	I have read or have had explained to me the information contained in the Vaccine Information Statements (VIS) about the vaccine(s) I have requested to be administered today. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on this form be given to me or the person named on this health record for who I am authorized to make this request.
	I agree to allow the health care provider giving vacinations to release information about all vaccinations given to me, or the person for whom I am authorized to give this consent, to the Arizona State Immunization Information System(ASIIS), other health care providers and schools in order to avoid receiving unnecessary vaccinations and to provide information about what immunizations have been received. I understand that I am not required to agree to the release of this information in order to receive the vaccinations I request. (If I do not wish this record to be included in ASIIS, I have the option of crossing out the above boxed statement and initialing it.)

_____

Name/ Title of Vaccine Administrator Date Given